OAH 66-0900-31984

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Haven Homes (IIDR) **RECOMMENDED DECISION**

This matter came before Administrative Law Judge Thomas W. Wexler for an informal dispute resolution meeting on December 22, 2014. The meeting concluded on that date.

Christine Campbell appeared on behalf of the Minnesota Department of Health (MDH). Mary Cahill also attended on behalf of MDH. Holly Kranz, the compliance survey team leader, testified on behalf of MDH.

Rebecca Coffin, Voight, Rode & Boxeth LLC, appeared on behalf of Haven Homes (Facility or Home). Jessica Sellner, Sue Boyd, Diane Lynch and Renee Anderson also attended on behalf of the Facility. Angie Tormanen, the Nursing Supervisor, and Brenda Anderson, an LPN at the Home, testified on behalf of the Facility.

Based upon the testimony and exhibits submitted at the resolution meeting, the Administrative Law Judge makes the following:

## RECOMMENDED DECISION

1. The Commissioner of Health (Commissioner) should further recommend that tag F282 be set aside as the evidence does not establish a deficient practice.

2. The Commissioner should further recommend that tag F314 be set aside because the evidence does not establish a deficient practice and the outcome was unavoidable.

Dated: January 6, 2014

s/Thomas W. Wexler

THOMAS W. WEXLER
Administrative law Judge

Reported: Digital Recording; no transcript prepared

## NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) (2014), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within ten (10) calendar days of receipt of this recommended decision.

## MEMORANDUM

### General Statutory and Regulatory Background

This matter arises out of a state compliance survey conducted at the Facility between September 8 and 12, 2014.[1]

Participation requirements for skilled nursing and long-term care facilities in the Medicare program are set forth in 42 C.F.R. pt. 483, subp. B (2014). Provisions governing the surveying of such entities and compliance enforcement are set forth in 42 C.F.R., pt. 488, especially subp. E, F (2014).

Compliance with participation requirements is monitored by periodic surveys by state agencies such as the MDH. The state agency reports any deficiencies on a form called a "Statement of Deficiencies and Plan of Correction" (form CMS 2567).[2]

A "deficiency" is a failure to meet a participation requirement in 42 C.F.R. 483, subp. B.[3] Deficiencies are designated by alpha-numeric "tags" corresponding to a regulatory requirement in Part 483 (2014).

The survey findings also include a determination as to the severity of each deficiency.[4] The seriousness of a deficiency depends on both its "scope" and its "severity."[5]

When citing deficiencies, the state surveyors use the CMS Guidance on Deficiency Categorization. There are four levels of severity and three columns of scope. The range of deficiencies is set out on a grid. Each square on the grid has a letter designation. "A" is the least serious and "L" is the most serious.[6] On the bottom row of the grid are the least serious deficiencies and the top row are most serious in terms of harm or threatened harm to the resident.

If a facility is not in substantial compliance, CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiency

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[1] MDH Ex.J.
[2] Centers for Medicare and Medicaid Services (CMS).
[3] *See* 42 C.F.R. § 488.301 (2014)
[4] *See* 42 C.F.R. § 488.404.
[5] *See* 42 C.F.R. § 488.404(b).
[6] MDH Ex. D.

pursuant to a plan of correction.[7] Depending upon the severity of the deficiency, CMS may also impose intermediate remedies, such as monetary penalties, for each day the facility was not in substantial compliance with the participation agreement.[8]

A facility may request an informal opportunity to dispute condition-level survey findings.[9]

On October 10, 2014, MDH issued a statement of deficiencies (form CMS 2567) following survey of the Facility.[10] The statement designated certain "F-Tags." Only two of those F-Tags were in dispute at this resolution meeting. Both of the disputed F-Tags relate to the care of resident number 56 (R56). The disputed F-Tags are F282 and F314.

F282 relates to failure to ensure the care plan for repositioning of resident R56. This tag was issued at a severity level E,[11] which means a pattern deficiency that results in no immediate jeopardy and no actual harm, but has potential for more than minimal physical, mental and/or psychological discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.[12]

F314 relates to failure to ensure interventions as assessed and to re-evaluate to prevent new pressure ulcers from developing. This tag was issued at a severity level G,[13] which means an isolated deficiency that results in actual harm that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.[14]

MDH had also cited tag F278, failure to ensure accuracy of the Minimum Data Set, resident status assessment, for R56, but MDH has agreed that citation is to be withdrawn.

As to F282, the Facility contends that it had qualified staff who knew of the policy to provide repositioning of R56 every two hours and that was routinely done, although it was exceeded on the day of observation, September 10, 2014. The Facility also alleges that R56 often resisted repositioning when offered. The Facility requests that references to R56 be removed from F282 because it was in substantial compliance with the regulations.

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[7] *See* 42 C.F.R. §§ 488.400, subp. F *et seq.*
[8] *Id.*
[9] *See* 42 C.F.R. § 488.745; Minn. Stat. § 144A.10, subd. 16 (2014).
[10] MDH Ex. J.
[11] *Id.* at J-13.
[12] Facility Exs. C, D, G-J.
[13] *Id.* at J-25.
[14] Facility Exs. C, D, G-J.

As to F314, the Facility contends that the pressure ulcers that R56 developed were "unavoidable" and that it was in substantial compliance with the regulations in assessing, monitoring, and providing appropriate interventions to address R56's pressure ulcers. The Facility requests that this F314 be rescinded.

"Substantial compliance" is a term of art. 42 C.F.R. § 488.301 defines substantial compliance as follows:

> Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

"Minimal harm" is not specifically defined. However, 42 C.F.R. § 488.404(b) establishes guidelines to determine the seriousness of a deficiency, as follows:

> (b) *Determining seriousness of deficiencies.* To determine the seriousness of the deficiency, CMS considers and the state must consider at least the following factors:
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> (1) Whether a facility's deficiencies constitute-
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> (i) No actual harm with a potential for minimal harm;
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> (ii) No actual harm with a potential for more than minimal harm, but not immediate jeopardy;
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> (iii) Actual harm that is not immediate jeopardy; or
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> (iv) Immediate jeopardy to resident health or safety.
>
> (2) Whether the deficiencies-
>
> (i) Are isolated;
>
> (ii) Constitute a pattern; or
>
> (iii) Are widespread.

Seriousness of a deficiency thus involves two components: level of harm to the resident and scope of the conduct in the facility.

There are voluminous studies and writings addressing pressure sores (commonly referred to as pressure ulcers). The writings address evaluation of susceptibility to ulcers, care practices to avoid ulcers (especially frequency of repositioning), periodic re-evaluations as may be required to modify care practices for a particular resident, bed and chair devices, off-loading practice, and wound cares. Pressure ulcers are one of the principal concerns of hospital and nursing facility care, and thus, are specifically

addressed in the C.F.R. and extensively addressed in the survey regulations. 42 C.F.R. § 483.25(c) provides as follows:

> (c) *Pressure sores*. Based on the comprehensive assessment of a resident, the facility must ensure that—
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> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
>
> (emphasis added)

What is "avoidable" and "unavoidable" is defined as follows:

> "Avoidable" means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
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> "Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.[15]

Nursing facilities and skilled nursing facilities are not unconditional guarantors of favorable outcomes, but the regulations on quality of care impose a duty to provide services designed to achieve those outcomes to the highest degree practicable.[16]

The surveying agency has the burden of setting forth the factual basis for its determination that the facility was not in substantial compliance. It must also produce evidence related to any disputed statement of fact.[17] MDH has met that minimal burden. This does not appear to be a burden of proof, but rather a burden of production. When that showing is made, then the burden shifts to the facility to show that the alleged

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[15] State Operations Manual (SOM), MDH Exhibit G-2. The SOM is actually a federal document that includes regulations for facilities enrolled in the Medicare/Medicaid program.
[16] *Florence Park Care Center v. CMS,* HHS departmental Appeals Board, Appellate Division, July 13, 2004 (MDH Exhibit E, at E-9).
[17] *Id.* at p. E-12.

deficiencies were isolated and did not increase the risk for the affected resident to potentially cause more than minimal harm.[18]

**Course of Treatment for Resident Number 56**

Resident 56 (R56) is a male born January 21, 1923. He was admitted to the Facility on December 10, 2013. He was then 90 years of age, was 5' 9" tall and weighed 133.2 pounds. He had multiple diagnoses upon admission including the following:

A. Benign prostatic hyperplasia/bladder outlet obstruction.

B. Hypertension.

C. Diabetes mellitus type II.

D. Foot drop.

E. Hyperglycemia

F. Mild leukocytosis.

G. Weakness.

H. Bilateral pressure ulcers on his heels.

I. A pressure ulcer on his coccyx.

J. He was alert and oriented.

K. His speech was clear.[19]

A comprehensive care plan was developed upon admission.[20]

The tags in this case relate primarily to the alleged failure of the Facility to properly address the requirements directed to avoidance of pressure ulcers. Thus the findings and discussion here will focus on those allegations.

The coccyx ulcer, that was present on admission was 1.3 x 0.3 cm, was an open ulcer within a larger red rash area. The ulcer resolved by January 2, 2014, and the Facility continued to monitor the area thereafter.[21]

The bilateral heel ulcers never resolved.[22] There is no contention that the Facility did not adequately monitor and care for the heel ulcers. It appears that they were well cared for and that these vulnerable ulcers never became infected. The care and

[18] *Id.*at p. E-13 and 42 C.F.R. § 488.301.
[19] Facility Exs. 1, 34 (p. 1).
[20] Facility Ex. 34.
[21] Facility Ex. 2.
[22] Facility Ex. 3.

treatment of the heel condition is relevant here. It shows the regularity of doctor visits, the doctors' primary concerns for patient welfare, and that it likely required bed positioning with feet elevated, a regimen that heightened stress to the buttock area.[23] The Facility records reflect regular attention to and treatment of the heel ulcers. R56 was seen on approximately a monthly basis by Dr. Jennifer Rysso at Ridgeview Medical Center for treatment of his heel ulcers.[24] Dr. Rysso was R56's primary care doctor.

R56 was seen on or about March 14, 2014 by Dr. Dawn Stapleton at the Lakeview Clinic, who performed a wound debridement on the heel ulcers.[25]

R56 was also being seen for the heel ulcers by a Wound, Ostomy and Continence Nurse (WOC or WOCN). On May 13, 2014, the WOC felt that she did not have anything further to offer R56 with respect to his heel ulcers and recommended referral to a formal wound clinic.[26]

R56 was also seen by Dr. Matthew Melin, a vascular surgeon, on June 2 and again on June 25, 2014. Dr. Melin diagnosed probable peripheral arterial disease, he viewed the heel ulcers, did not recommend revascularization, but did discuss the option of hospice care. He specified cares for the foot ulcers.[27]

Dr. Rysso's exam records reflect approximate monthly visits from March 2014 through June 2014, after which R56 was seen more frequently. He was seen three times in July and again on August 1, 2014.[28] None of these progress notes mention pressure sores on his gluteal area, sacrum or coccyx, although Dr. Rysso was notified of these developments by the Facility as they appeared and as hereafter noted.

On June 17, 2014, the Facility first noted two areas of skin breakdown on R56's gluteal folds. There was a red raised area on his left gluteal fold[29] and an open area on his right gluteal fold.[30] The left gluteal fold condition resolved by July 9, 2014. The right gluteal fold condition was consistently monitored, but did not heal. Dr. Rysso was promptly informed on June 17 of the of the gluteal fold issues and she sent an order for that skin care.[31]

On June 19 nursing requested a change from the doctor for treatment of the right gluteal fold to use an alternative dressing with border.[32]

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[23] Facility Exs. 4-10, 18, 46.
[24] Facility Exs. 11-17, nursing visit summaries.
[25] Facility Ex. 31.
[26] Facility Ex. 17.
[27] Facility Exs. 29, 30.
[28] Facility Exs. 20 to 28.
[29] Facility Ex. 41.
[30] Facility Ex. 42.
[31] Facility Ex. 43, nurses note on June 17, 2014.
[32] Facility Ex. 43, p. 8.

The progress notes reflect continuing attention to the cares of the gluteal fold and other buttock area ulcers.[33]

On June 21, 2014, R56 complained about his Stimulite chair cushion because it felt like he was sitting in a hole.[34] The nurse consulted with physical therapy and it was decided to provide a vector pressure redistribution cushion.[35] The nursing staff then did a sitting tissue tolerance assessment on 6/23/2014 and a new Braden scale evaluation on that same day.[36]

Dr. Rysso's report of July 18, 2014 opines that R56 has experienced significant gradual decline in overall medical status and suggested that the code status be changed to comfort care status.[37]

On July 27, the Facility noted a new open wound on R56's right buttocks.[38] The doctor was notified, prescribed treatment and the Facility implemented the treatment.[39] The new open area was not likely due to repositioning issues. It was likely the result of trauma from the adhesive edge of the right gluteal fold dressing.[40] The Facility then requested permission from the doctor to change the wound dressing to prevent further fragile skin trauma.[41]

On August 24, 2014 nursing noted a new reddened area on R56's sacrum/coccyx region, requested a treatment order, and on August 25, 2014, Dr. Rysso was notified of the reddened area.[42] Dr. Rysso observed the reddened area on September 5.[43] The Facility again notified the doctor, received and carried out care instructions, and completed a new tissue tolerance assessment which concluded that the same repositioning schedule was appropriate.[44]

R56 was vulnerable to skin issues. In addition to his foot, sacrum and buttock skin issues, he had skin issues with his scrotum, elbows, finger, left bunion, bottom side of penis, both hands, and right lateral foot.[45] Some of these issues resolved with Facility

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[33] Facility Ex. 43 on dates of June 19, 20, 21, 22; July 9, 12, 14, 16, 18, 27, 28, 31; August 1, 12, 24, 25; and September 1, 3, 5, 6.
[34] Facility Ex. 43, nurse's note 6/21/2014.
[35] Facility Ex. 43, note 6/21/2014, Exs. 7-10; Testimony of Brenda Anderson.
[36] Facility Exs. 35; 38.
[37] Facility Ex. 22.
[38] Facility Ex. 43.
[39] Facility Exs. 8-10.
[40] Facility Ex. 43, nurse's note 7/31/2014.
[41] *Id.*
[42] Facility Ex. 32; Ex. 43, 8/25/14.
[43] Facility Ex. 43, 9/5/14.
[44] Facility Exs. 9, 10, 35, 43.
[45] Facility Ex. 43, skin injury notes of: Buttocks 8/28/14, 9/5/14; Scrotum 5/12/14, 5/27/14, 6/21/14, 8/1/14 (resolved); Right hand 5/18/14, 5/19/14, 6/23/14 (resolved); General 5/28/14; Elbows 6/8/14 (resolved), 6/20/14 (new elbow injury), 6/23/14, 7/20/14 (resolved); Clipped finger 6/24/14, 6/25/14, 7/3/14 (resolved); Bunion 6/29 - 7/1/14, 7/21/14, 7/23/14; Right lateral foot 7/7/14 (resolved); Penis 7/14/14, 7/16/14, 7/18/14; Back of left hand 8/28/14.

care as noted in the footnote below. A few of the skin issues resulted from what appear to be mild traumas.

R56 was not always cooperative with attempts to reposition him.[46] On at least two occasions, June 21, 2014 and July 12, 2014, he was counselled about the importance of repositioning.[47] As part of his repositioning regimen, R56 was scheduled for bedrest in the A.M. and the P.M.[48] R56's wife, who also resides in the Facility and was regularly attendant with R56, agrees that R56 did not always want to be repositioned.[49] On other occasions, when R56 was resistant to repositioning, Facility staff would off-load him.[50]

The Facility regularly followed physician orders, WOC recommendations, and their own assessments. [51]

The Facility performed tissue tolerance evaluations, predisposing disease risk evaluations, and Braden scale assessments of R56.[52] There were seven tissue tolerance evaluations between January 10, 2014 and August 25, 2014.[53] There were three Braden evaluations—in March, May and June 2014—which indicated mild risk for ulcers, but the Facility treated him as "high risk" notwithstanding the lower Braden score.[54]

The facility was implementing a variety of cares to address R56's multiple needs, including turning and repositioning, elbow protectors, elevating his legs, creams, sheep skin on wheelchair arms, changing ulcer dressings and applying medications, pressure guard air mattress, cushion for the wheel chair or room chair, and diabetic diet with protein supplement to assist with wound healing.[55]

Dr. Rysso was concerned about R56's diet. Based upon Dr. Rysso's order, the facility performed a dietary assessment. The assessment recommended that they continue with the current diet which included nightly snacks and protein supplements. R56's weight had remained stable.[56]

R56 has recently been moved to hospice care.[57]

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[46] Facility Exs. 51, 52; Test. of B. Anderson.
[47] *Id.*
[48] Facility Exs. 5-10.
[49] Facility Ex. 50.
[50] Test. of B. Anderson.
[51] Facility Exs. 4-10.
[52] Facility Exs. 35-40.
[53] Facility Ex. 35. The CMS 2567 notes some apparent inconsistencies in the evaluations with respect to ability to reposition independently in the lying position. However, the care plan did not change and continued to require repositioning intervals not to exceed two hours.
[54] Facility Ex. 36; Test. of B. Anderson.
[55] Facility Exs. 4-10, 34 (care plan and p. 10).
[56] Facility Exs. 21, 43 (note of 8/12/2014).
[57] Advice at the meeting.

It is undisputed that on one survey day, September 10, 2014, R56 was not repositioned or off-loaded within two hours. However, that appears to be an exception to the common practice at the Facility and there is no evidence that one occasion caused R56 any harm.

**Analysis**

None of the literature that has been presented or researched by the undersigned states that frequent repositioning of a resident assures that pressure ulcers will not occur. It appears that a pressure ulcer can begin within two to six hours.[58] Typically the ulcer commences below the epidermis, in the dermis, and progresses outward due to bony pressure on the skin. The appearance of the ulcer may not become apparent for days after it begins. An ulcer can also be precipitated by shear and friction forces, which can occur when a resident is moved on bed sheets.[59] A white paper publication of the National Pressure Ulcer Advisory Panel (NPUAP) states that pressure ulcers occurring at the end of life are often not preventable, because of the frail condition and co-morbidities.[60]

The determination that an ulcer is a pressure ulcer cannot be made based merely on its location over a pressure point. It could also be precipitated by a shear event.[61]

Of course, the resident's failing condition would not justify failure to implement appropriate cares to minimize pressure ulcer risk. However, the preponderance of the evidence in this case is that the Facility regularly repositioned R56 to minimize the risk of pressure ulcers. That conclusion is supported by the following:

1. That the sacrum ulcer present upon admission resolved.

2. There were no new pressure ulcers for six months after admission.

3. The left side gluteal fold ulcer, that appeared on June 17, 2014, resolved by July 9, 2014.

4. The Facility was devoting regular attention to skin issues by performing tissue tolerance tests and Braden Scale assessments and considered R56's status to be high risk in spite of the Braden scale score.

5. R56 was frequently resisting repositioning, staff had to counsel R56 about the importance of repositioning.

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[58] MDH Ex. G-6.
[59] MDH Ex. G-2.
[60] *"Pressure Ulcers in Individuals Receiving Palliative Care: A National Pressure Ulcer Advisory Panel White Paper,"* Advances in Skin and Wound Care, February 2010. CMS acknowledges NPUAP as an authoritative agency, MDH Exhibit M-32.
[61] MDH Ex. M-32.

6. Doctors were promptly notified of the presence of new ulcers and orders obtained and implemented.

7. The treatment of ulcers was effective to prevent infection.

8. R56 was provided with a special air mattress for his bed.

9. R56 was provided with a therapeutic chair cushion and months later, when R56 reported it to be uncomfortable, the Facility provided him with a new therapeutic cushion which R56 found to be comfortable. MDH argues that there was no appropriate evaluation of the new chair cushion by Occupational Therapy, but R56 found it comfortable and Physical Therapy recommended it.

10. The medication administration records reflect consistent attention to all of the cares prescribed in those records, some of which were prescribed to prevent skin breakdown and to assist with healing.

11. The primary healing concern from admission onwards was always the open heel wounds, and they were well cared for. Though they never healed, they did not become infected. No one contends that there was any deficiency in the Facility care of the heel pressure ulcers.

12. The records reflect that there were many doctors visits and constant communication to and from the doctors relating to many aspects of R56's care. There were at least 55 days recorded in the nurses' notes where there was at least one communication with a doctor and there was more than one such communication on many of those days. Many of those communications related to the ulcers on the sacrum and gluteal fold, requesting advice and change orders in the cares.

13. The Facility had a repositioning policy and a wound care policy. Each of those policies assigned qualified staff to those responsibilities.[62]

All of these facts support the conclusion that the Facility paid careful attention to the risk of pressure ulcers, and to the cares required to prevent pressure ulcers.

There is admitted evidence that the Facility did not reposition R56 for more than two hours on September 10, 2014, perhaps for much more than two hours on that day. No actual harm is shown to be related to that incident. The best evidence is that the September 10 incident was an isolated occurrence, and MDH has classified it as an isolated occurrence.

[62] Facility Exs. 48, 49.

R56 was not always in the care of the Facility at times possibly relevant to the development of the gluteal fold pressure ulcers on June 17, 2014. On June 2, 2014, R56 was taken by transport to the Methodist Hospital Wound Clinic. He left the Facility at 9:15 A.M. and returned at 12:30 P.M.[63] It is foreseeable that the beginning of pressure ulcers could happen during that time.

R56 was also transported to the hospital on May 6, 2014, during which time he was gone from 10:45 A.M. to 4:00 P.M.[64]

Another ulcer appeared on July 27, 2014, but this appears to be related to trauma caused by removal of a bandage/dressing from one of the gluteal ulcers. The Facility promptly contacted the doctor to request approval for use of a different dressing and that request was approved. This was not a pressure ulcer.

One other pressure ulcer appeared on the sacrum on August 25, 2014.

The requirement that the heels had to be elevated in bed likely made repositioning more complicated to avoid backside pressure. Without minimizing the need to relieve backside pressure, it is undeniably true that the heel ulcers were always the primary concern, and that the potential of serious infection and leg amputation was avoided by the attentive care provided.

R56's wife also resided in the Facility[65] and was regularly involved with R56 and with his care. She signed a statement that should be fairly interpreted to mean that repositioning was commonly provided at appropriate intervals, and that R56 sometimes declined repositioning when offered. She also acknowledges that the Facility advised of the risk of not repositioning every two hours.

A CNA was interviewed by the survey team and was understood to say that sometimes they could not get to R56 for repositioning every two hours. That CNA provided a statement, however, that when she was on duty she always repositioned R56 every two hours. However, the CNA also appears to state that R56 sometimes refused to be repositioned.

There are very few, if any, chart reports of pain complaints by R56 associated with the gluteal fold and sacrum pressure ulcers. It appears the Facility was appropriately managing the comfort level of R56 related to the pressure ulcers. On September 10, 2014, R56 did tell the survey interviewer that he had pain in the buttocks at that time.

The Facility contends that R56's co-morbidities, especially his diabetes, impaired circulation and low prealbumin levels,[66] made the pressure ulcers on his sacrum and buttocks unavoidable. All of these conditions are well known to impair skin health. The

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[63] Facility Ex. 43.
[64] *Id*.
[65] Facility Ex. 34, p. 6 of 16.
[66] Facility Ex. 25.

prealbumin levels were in the range of 8 to 9, which indicates malnutrition and in turn relates to the ability of skin cells to regenerate. The doctors were informed of the lab results and ordered diet supplements which were provided by the Facility. R56's weight was stable.

Fecal incontinence is known to exacerbate vulnerability to skin ulcers.[67] R56 suffered from such incontinence.

R56 received necessary treatment and services to promote healing. Individualized procedures were observed in the care and treatment of R56 and of his susceptibility to pressure ulcers. R56's ulcers were treated appropriately and consistent with doctor recommendations. Doctors were kept informed. R56 did not experience significant discomfort associated with the pressure ulcers and was generally comfortable.

The evidence and exhibits reflect that R56's condition and multiple comorbidities were well-evaluated upon admission, and that his pressure ulcer risk factors were noted and an appropriate care plan developed and implemented consistent with R56's needs. He was evaluated as at high risk for pressure ulcers and placed on two hour repositioning from the inception of his residence.[68] The preponderance of the evidence is that the care plan was appropriate and consistent with the standards of practice.

## Conclusion

The Administrative Law Judge recommends that the Commissioner further recommend that the "G" level deficiency issued under F314, and the "E" level deficiency issued under tag F282 be set aside.

**T. W. W.**

[67] MDH Ex. G-8.
[68] Facility Ex. 4 at entry of 1/9/14.